SJ-EXHIBIT 44

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

- - -

IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION	:	MDL No. 2804
	:	Case No. 1:17-md-2804
THIS DOCUMENT RELATES TO:	:	
The County of Lake, Ohio v. Purdue Pharma, LP, et al. Case No. 18-op-45032	:	Hon. Dan A. Polster
The County of Trumbull, Ohio v. Purdue Pharma, LP, et al. Case No. 1:18-op-45079	:	
Track 3 Cases	:	

Friday, April 16, 2021
HIGHLY CONFIDENTIAL
SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

Remote videotaped deposition of EMILY MOONEY, conducted at the location of the witness in Chardon, Ohio, commencing at 10:02 a.m., on the above date, before Carol A. Kirk, Registered Merit Reporter, Certified Shorthand Reporter, and Notary Public.

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one.

Q. Okay. So tell me generally what happens as it relates to data verification. And then if you would, also tell me specifically what happened -- well, let's just start in general.

Tell me generally what happens at data verification, and then I'm going to ask you some more questions about controlled substances after that.

A. Okay. Well, I mean, I can use oxycodone as an example.

So data verification, it's similar. I put my biometrics in. A prescription will pop up on my screen. I have a picture of the hard copy prescription on the right-hand side of the screen, and then what my technician inputted into the system on the left-hand side.

The computer system that we have now, it's pretty nice. It goes line by line. So I can hit enter to check each line. So similar to data entry, it is the same. I'm checking the name and date of birth.

So when I am checking the name, I'm making sure that the name is correct, the date of birth matches. I also -- in my head, I'm looking for, you know, age. Is this a pediatric patient, an elderly patient?

Next I would check the drug, make sure that the drug is what is on the prescription. So I check the drug, the strength, and the form, whatever that may be, a tablet, a capsule, extended release suspension, make sure that those match up.

After that, I check the quantity, the refills, the doctor. With the doctor and an oxycodone prescription, I make sure that that DEA is there. I make sure -- MPI helps too, but I need to have the DEA there. That the prescription is signed. That happens a lot where it's not signed.

And in the respect of a C-II prescription or a controlled prescription, if it's not signed, then that script is not valid. If it's a hard copy, it would have to go back to the doctor's office to be signed or rewritten.

After I talk to the doctor, I go

back through the prescription and make sure the prescription makes sense, that the dosing is appropriate for that drug. And then I'll move on.

My next screen -- after doing the check of just the prescription, my next screen would be my DUR screen, allergies. Those would be listed there.

We have -- so if there's -- on a DUR screen, allergies can be one of them. If the patient has any other medications that are similar to it in the same class that they've recently gotten, I look through that.

In this old system, we wouldn't have a DUR screen. It was a little bit different. They kind of printed after the fact. So in that case, I would check their profile. And a lot of times, I still check the profile depending on what the DURs are telling me.

A lot of times patients are -- the oxycodone example, they might have got 5 milligrams last time, this one is for 10 milligrams. So I'm going to put a counsel note in to discuss that with the patient, that

there was a change in therapy.

At this point, I'd also check to see if the patient's filled that before, why the jump. And you can see if they've filled it in previous times, if they're filling it too early.

A lot of times even with a jump from 5 to 10 milligrams, I would do a calculation; "Okay. So should they have enough filled for getting this prescription at 10 milligrams, should they have enough of doubling up on their 5s to get them to a certain date before I fill this?" These are some of the things going through my head.

For an oxycodone prescription, an OARRS tab will show up in my computer system, and I have to click on that, or override it. And I never override it.

I'd click on that and check the OARRS report also on this screen, make sure they haven't filled at any other pharmacies, any other doctors.

Sometimes dentists, in particular, will write for prescriptions that -- for tooth pain and an immediate need, but they don't --

they don't typically check OARRS like I would. So.

I will see that, you know, they got an oxycodone prescription just the other day from a pain management doctor and now they're getting this. So that would flag me to check and call them -- call the doctor.

After the OARRS, as long as everything checks out okay, I can continue. The next screen sometimes is billing, but for the most part, that's the last screen I would look at. It just shows the -- what it's been billed to. And then I would put it in my biometrics to approve it as well, or reject it to the call queue depending on what the script is or if there's any issues.

If there was any change in dose, I would deactivate an old prescription and then put a counsel note, so then I would make sure to speak with the patient and make sure they're aware of a dose change.

Any questions I had, I would also put in a counsel note. If there was a question about an allergy or something like that, I would

do that at that screen as well.

I think that covers most of the -- just some of the process with data verification.

Q. Okay. Let me ask you a couple follow-up questions about that while it's still fresh in your mind, and then we can take a break, if that's okay.

That whole process that you just described, the data verification, about how long does that take you?

A. It depends on the prescription obviously. I mean, there's a lot of what-ifs, a lot of things. It depends on what I see. So, I mean, a controlled prescription typically takes longer because I will check that OARRS. There's more information that needs to be on the prescription than on a standard legend drug.

I mean, I would say for a normal maintenance med prescription, I'd say a minute or so, maybe more, depending if there's any interactions, because I can check -- we have tools, if there's an interaction that I can check and make sure that the interaction is something I can counsel them more on or if it's

something I need to call the doctor on and change the drug completely.

So I would say on average, about a minute. I would say controlled medications, typically longer just because of the OARRS report and the more detail that is required there. Probably double the time, I would say.

Q. Okay. So as far as how long it takes for you to do the data verification process, you said for a normal non-controlled medication, approximately a minute. But when we're dealing with a controlled substance, such as an opiate, approximately two minutes to do the data verification process.

Is that fair?

A. Yes, as long as there's no issues. Yes.

Q. Okay. One of the things that I heard you say in your answer that you would look at during the data verification process would be the dosing and the length of treatment, and I think you said you would look at those types of things to see whether or not they made sense.

Do you recall that generally?

A. Yes.

Q. Okay. And you agree that those are the types of things that fall within your job responsibilities as far as performing due diligence in carrying out your corresponding obligation regarding whether or not a prescription, particularly for a drug like an opiate, should be filled?

MR. MAZGAJ: Objection to form.

A. I -- it is my corresponding responsibility to do that for every prescription, no matter what. So that is in my process for every prescription. I need to know that it makes sense the way that it is written.

Q. You mentioned a couple of times -- you used the term "counseling note." I'm making an assumption that that means talk to the patient when they come to pick up their prescription; is that right?

A. Right.

Q. Okay. Are there any -- and you've told me about a couple of instances where you do things maybe a little over and above that maybe aren't necessarily required by the company, but

Q. I think you referred to this section of the Controlled Substance Dispensing Guideline in your testimony, but we didn't walk through it, so let's go to page 4 of that document. And if you could just read that paragraph for me real quick, and we'll talk about it, out loud.

A. Okay. "Giant Eagle supports the professional judgment of each pharmacy team member. If after performing required due diligence and in the exercise of his or her professional judgment, a pharmacist determines that a prescription should not be filled, Giant Eagle will support the decision. No team member may try to coerce a Giant Eagle pharmacist to fill a prescription that in his or her professional judgment and after appropriate investigation should not be filled. Any coercion will be considered an ethics violation and will be reported and disciplined according to the Giant Eagle code of ethics."

Q. Okay. And then just generally, has this been your experience while working for Giant Eagle?

A. Yes, completely. I have the full support of the company for my expertise as a pharmacist. I think it shows in the fact that I have worked for Giant Eagle my entire career, that they have the same morals, ethics that I do, and I wouldn't -- I couldn't morally, ethically, legally work for a company that does not share those values.

Q. So as far as values, what do you mean by that? What's kind of the core value that drives your practice?

A. Solely, I want to help people. I do. I've always been that way. I have a family of three girls, and I want to show my girls that you're supposed to do the right thing and help people. And fortunately I have a job that I can do that in, and I can show them how important that is for them as they grow.

Q. And so helping -- and I'm going to combine two things here. I think that you testified correctly that you assess each prescription of each patient individually; is that accurate?

A. I do. Yes.

Q. Okay.
A. I take many things into account.
Q. So when you're helping individual people, why is it important to treat each patient and each prescription individually?
A. I'm not a robot. I am a professional with a degree, with a license. And I think I owe it to every patient to give them and give their prescription my full attention and my expertise so that they get the prescription, the dose that they need, and come back for that reason, is to keep them safe.
Q. Yeah, and so I guess as a general matter, you would never fill a prescription that you didn't think was safe?
A. Never.
Q. Okay. And another word that you said in there was "license." Is it my -- is it correct that any individual prescribing a prescription, especially an opioid, must have a license to do so?
A. Yes. They would need a license to do so.
Q. Okay. So you only distribute --

or dispense opioid medications that are written by someone who is licensed to do so?

A. Correct.

Q. And that goes back to the DEA number being required, and you're checking to make sure that they are a licensed and active medical professional; is that correct?

A. Yes.

Q. Okay. So back to Exhibit 9 again. So we go through, and you talked about performing due diligence. You have the support of Giant Eagle.

The next part is about, "No team member may coerce a Giant Eagle pharmacist to fill a prescription that in his or her professional judgment and after appropriate investigation should not be filled."

Has anyone ever coerced you into filling a prescription that you didn't think was appropriate?

A. No.

Q. Now, if a customer comes in and complains about you not filling an opioid prescription, does that change your evaluation

of an individual prescription?

A. No. No. They --

Q. How do you treat -- we just went over for a while the customer surveys. We -- you touched on it a little bit, that you would address individualized negative -- or negative reports.

Can you walk us through how that might look?

A. If a negative or customer complaint comes into the pharmacy, it would come through as an e-mail with -- from a customer care agent, someone -- like a 1-800 number that they would call and put a complaint in. They document that complaint and then send it to the pharmacy with the patient's info.

So then I can read through the complaint, associate what's going on to that complaint, and then deal with -- deal with that complaint, calling the customer back, seeing if we can make something right, re-teaching to employees.

Q. So I take it that you take customer complaints very seriously; is that

true?

A. I do. Yes.

Q. But would a customer complaint ever change your professional judgment and cause you to change a decision on an opiate prescription?

A. No.

Q. Okay.

A. No.

Q. We talked -- or you talked a bit today about your bonus. I want to talk about that briefly. And I guess the financials of Giant Eagle in general.

Has anyone ever told you, Emily Mooney, that the Painesville pharmacy needs to make more money?

A. Never.

Q. Have you been told to -- well, let me do it this way. Have you been told that you need to sell more scripts?

A. Never.

Q. How would you do that if -- even if they told you you had to sell more prescriptions, how do you do that? Do you have